the human Mantoux.1 If skin testing is equivocal, or in cases of infection involving potentially vulnerable sites (such as the mastoid), when adjacent antimycobacterial drug treatment is given, then it may be helpful to have the surgical procedure examined by the polymeric chain reaction.4 This allows differentiation between M tuberculosis and NTM infection, although the specificity and sensitivity of the polymerase chain reaction in this setting is not known. Thus appropriate antimycobacterial treatment can usually be given long before mycobacterial culture results are available at 2–3 months, and the choice of treatment does not rely solely on clinical features.

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Overnight oscillations of rectal temperature

EDITOR.—We have previously reported from New Zealand regular variations of overnight rectal temperature in infants.1 The periodicity is about one hour and the amplitude up to 0·3°C. These infant rectal temperature oscillations were found in 24 (80%) of 30 continuous overnight recordings. We have now examined a further 98 overnight recordings of rectal temperature that were part of a study by Wallow MP et al from Leicester.2 These recordings were classified by the infant’s state of health:2 ‘well’ (n=24), ‘incubating illness’ (n=44), or ‘unwell’ (n=30). Regular oscillations were observed visually in 68 (69%) of 98 overnight recordings, similar to the 80% reported from New Zealand. Using power spectral density and digital filtering techniques, confirmation, and measurement, of regular oscillations were found to be present in 55 of these 98 recordings. Temperature oscillations were seen equally in all three health groups of the infants. Also there was no change seen in the proportion of infants with oscillations with increasing age.

The mean period of oscillations in the Leicester babies was 59·2 minutes (range 46·5–73·2); this compares well with the 58 minutes as discovered by Brown et al.1 Well infant records had oscillations with a slightly longer period (mean 63·4 minutes) than unwell infant records (mean 57·2 minutes) (p<0·05) with those incubating illness in between (mean 58·6). The oscillatory period was significantly shorter for infants over 12 weeks (mean 57·1 minutes) than for infants under 6 weeks (mean 62·5 minutes), with infants 6–12 weeks falling in between (mean 59·2).

We have shown that the presence of overnight temperature oscillations is a consistent characteristic of early infancy, occurring both in health and illness.

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Compliance with growth hormone treatment—are they getting it?

EDITOR.—We previously reported that only 48–9% of our patients treated with recombinant human growth hormone (rGH) complied in all aspects.1 We identified patient education and rGH reconstitution as the major contributory factors and, as a consequence, offer patients a choice of rGH preparation appropriate to their needs and a hospital based clinical nurse specialist to train them in its use at home. We have now administered the same questionnaire to a new group of patients.

Patients attending over a two month period were asked to complete a questionnaire if they were receiving rGH. The questionnaire designed to assess level of understanding and compliance with treatment was accepted by 177 patients. Altogether 105 (59%) (group 1) had started treatment before the change in policy; 64 (36%) (group 2) had been trained by a clinical nurse specialist at home. Eighty one per cent of patients in group 2 had a good, 10% an adequate, and 9% a poor understanding of the therapeutic regime compared with 50%, 34%, 15% respectively before (p<0·01). Patients in group 1, who had started rGH before the change in policy failed to improve their understanding of the therapeutic regime despite being seen at regular intervals at hospital visits by a clinical nurse specialist.

Compliance was assessed by questions designed to uncover the number of missed injections during a three month period. Fifty eight per cent of patients in group 1 complied with all aspects of their treatment, which was not significantly different from our previous experience; 84% of patients in group 2 complied with all aspects of their treatment (p<0·001).

Compliance in children prescribed rGH treatment has improved considerably. Initial training of the patient and family at home appears to be the most important element in achieving compliance.

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Morbidity from excessive intake of high energy fluids: the ‘squash drinking syndrome’

EDITOR.—Following the article by Hourihane and Rolles on the ‘squash drinking syndrome’1 we would like to take the opportunity to remind readers that excessive squash drinking may be associated with severe side effects than failure to thrive.2 Recently a 22 month old girl presented here with a generalised afibrile convulsion and pyrexia. She had previously been recognised elsewhere as failing to thrive, with her weight lying below the third centile. Her weight at presentation here was 8·7 kg. On questioning she was found to be drinking approximately two litres of squash a day, as she slept with a large jug of juice at the bedside.

Investigation revealed a serum sodium concentration of 114 mmol/l, potassium 4·0 mmol/l, urea 2·9 mmol/l, creatinine 54 μmol/l, glucose 5·2 mmol/l, and calcium 2·34 mmol/l with a simultaneous urinary sodium of 19 mmol/l and urinary osmolarity of 128 mmol/kg. Serum sodium rose to normal concentrations simply with fluid restriction to normal fluid requirements of around one litre a day. A water deprivation test subsequently revealed normal renal concentrating ability excluding diabetes insipidus as a cause for her polydipsia. The parents were advised to restrict squash consumption.

There have been no further fits on follow up over one year. Squash consumption has varied, but a normal serum sodium has been maintained. However, weight gain has been better at those times when squash consumption has been less excessive.

We agree with Hourihane and Rolles that excessive squash consumption is an important cause of failure to thrive. Additionally the possibility of water intoxication, with all its complications, should be considered if squash consumption is excessive.

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The art of communication with children

EDITOR.—The need to communicate well with children and their parents is fundamental to paediatric practice. Most of us see our own children, who are exposed to sick children as their doctor, but rarely do we get an opportunity to join them as normal adults with whom they can play and frankly discuss their problems. One way I learnt to understand children was to spend some weekends camping with the Woodcraft Folk, a recognised educational charity for children and young people. These camps are organised as

This new publication covers a range of surgical emergencies affecting children and gives some background to the surgical conditions and concentrates on first line management and investigation. It tackles subjects by clinical presentation rather than pathology and is aimed at the non-paediatric surgical specialty trainee, casualty, and nursing staff. It covers a wide range of presenting symp-

toms, though by nature of the book, many rather superficially.

This topic has been poorly covered by recent texts, the majority of which have been major in-depth texts, unsuitable for quick reference by non-specialist staff. It is well

laid out with short paragraphs, an easily readable concise style, bullet lists, and subtitles.

It is a shame that in the first chapter on emergency surgical admission, there is no stress on basic resuscitation, neither do APLS (ATLS) techniques appear here nor as a preface to a general trauma section. The illus-

trations are well chosen and helpful, though a few more examples of practical procedures would be useful, such as suprapubic aspiration and reduction of hernia. It would also be useful to have covered the role of the regional and supraregional specialist unit and transfer of the sick child, in particular neonates. The authors have set out to cover a large subject in an easily accessible format. The cost of this to some extent has been to lose any impression of the multitude controversies that exist within paediatric surgery. In picking a simple treatment plan, there are management suggestions that would not be acceptable in other centres in the UK, for example, that it is ever preferable to perform a pyloromyotomy under local anaesthesia or that it should ever, with careful management of the underlying electrolyte including potassium deficiency, be impossible to correct the electrolyte imbalance.

In general I feel the book is well written, well presented, with good illustrations. It will form a much needed up-to-date source of reference for medical students, nursing staff, and junior hospital doctors in the non-specialist environment.

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Recent Advances in Paediatrics – 13. Edited by T J David. (Pp 235; £26.50 paper-


‘When I was a boy: World a better spot

What was so was so: What was not was not’

There are different approaches to the problem of keeping up to date. The least effective is that of the ostrich, stick your head in the sand